*SUGGESTED FORM*

**Mental Retardation Community Medicaid Services**

_____**NEW** _____**REVISION**
**FOR CSP YEAR** **FOR CSP YEAR**

**INDIVIDUAL SERVICE PLAN**
**THERAPEUTIC CONSULTATION**

Indicate Type:_____OT _____PT _____Speech _____Recreation ____Psychology _____Behavior _____Reh Eng

Individual: _____ Medicaid Number: _____

Provider Name: _____Provider Number: _____

Start Date:_____ End Date:_____ Quarterly Review Dates:_____ _____ _____ _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME:

| CONSULTATION OBJECTIVES | ACTIVITIES/STRATEGIES | PROJECTED HOURS |
|---|---|---|
| | | |

Individual: _____ TC Service:_____ Start Date:_____

CSP SELECTED GOAL/ DESIRED OUTCOME:

| CONSULTATION OBJECTIVES | ACTIVITIES/ STRATEGIES | PROJECTED HOURS |
|---|---|---|
| | | |

Individual: _____ TC Service:_____ Start Date:_____

| CONSULTATION OBJECTIVES | ACTIVITIES/ STRATEGIES | PROJECTED HOURS |
|---|---|---|
| | | |

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the consultant.*